Trauma Exposure Among Select Wisconsin Families in the Child Welfare System

2008-2010

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Introduction

In 2005, the Wisconsin Department of Health and Family Services created the Continuous Quality Improvement (CQI) Section and implemented the Quality Service Review (QSR) protocol to evaluate tribal and county child welfare systems. The Wisconsin Department of Children and Families (DCF) was created in 2008 and continued to use this review protocol to collect qualitative information about child welfare case practice across the state. Counties and the State of Wisconsin use the results of the QSR to create and implement post-QSR action plans, enhance local practice, develop statewide policy, and target training and technical assistance to improve outcomes for children and families at the local level. By the end of 2010, QSR's had been conducted in 57 counties.

Early in this process, the CQI Section learned that a high number of parents and children in the selected cases had been exposed to trauma. In February of 2008, staff began collecting information related to accounts of trauma-inducing events to which individuals are exposed during their lifetimes. This report seeks to inform DCF and its partners about the prevalence and types of trauma documented as part of the QSR.

Research

Current research has found adverse childhood experiences (ACES) to be the largest determining factor of the health and social wellbeing of the nation (Felitti, 2004). Annually, more than three million children are reported to Child Protective Services (CPS) for abuse and/or neglect, with one million cases being substantiated in the United States (van der Kolk, n.d.). Children experience community violence, medical procedures and accidental traumas, but most of the trauma experienced by children is a result of their parents' actions or lack thereof (van der Kolk, n.d.). Research suggests emotional and physical symptoms can be seen in adults as much as fifty-five years following the traumatic incident/s (Felitti, 2004). The results can be paralyzing to a person's social and physical well being, which can and often does stunt a parent's caregiving capacities. When unmitigated, exposure to trauma-inducing events impacts an individual's functioning across all domains including their social, physical, mental health and parenting capacities. Exposure can then cause generational trauma and patterns of neglect and abuse.

While trauma is remarkably common, it is most often concealed and unrecognized by professionals (Felitti, 2004). Research indicates professionals who are treating for post-traumatic stress disorder (PTSD) instead of trauma may actually be providing inaccurate treatment or "missing the boat" (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Many people who have been exposed to trauma had a higher prevalence of being diagnosed with PTSD and Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (van der Kolk, et. al, 2005). Interestingly, although age had no bearing on a person's diagnosis of PTSD, age was a main criteria for those also diagnosed with DESNOS (van der Kolk, et. al, 2005). The earlier a child is exposed to trauma, the more likely he or she is to suffer from PTSD and a cluster of DESNOS symptoms (van der Kolk, et. al, 2005). The American Psychiatric Association conducted a study in which they found those who had trauma, especially early in life, had a high

incidence of problems with "regulation of affect and impulses, memory and attention, self-perception, interpersonal relations, somatization and systems of meaning" (van der Kolk, et al., p. 391, 2005).

A detailed study of over 17,000 Americans found the compulsive use of alcohol and injected street drugs increased proportionally in a strong, dose-response manner that closely parallels the intensity of ACEs in a person's childhood (Felitti, 2004). Felitti indicates this information strongly suggests that the basic cause of addiction is related to the experiences an individual is exposed to rather than a physical dependence on a chemical (2004). This ideology challenges the usual theories of substance addictions being intrinsic to a person's biology. Addiction overwhelmingly implies ACEs, and instead of demonizing a chemical such as alcohol, professionals should recognize that the cause and effect of substance addictions actually lies within the family system (Felitti, 2004). However, it is critical to understand that no one category of adverse experiences, whether it is alcoholism or mental health issues, occur independently. A child does not grow up with a parent who abuses prescription pills where everything else in the house is fine. The idea of multiple traumatic experiences is crucial to understanding effective treatment.

Based on the studies of the effects of trauma, the effects present a massive problem that primary prevention may be the only realistic solution (Felitti, 2004). Research suggests reorganizing treatment programs towards working with the underlying cause (trauma) rather than the actual substance withdrawal (Felitti, 2004).

Sources of Data

In the calendar years 2008 through 2010, the CQI Section gathered information on 349 children and their parents. These families were involved with CPS in Wisconsin from 31 counties. The review process randomly selects children for the case review and refers to them as focus children.

The cases selected have been open for at least six months at the time of the review and form a stratified sample of children who are receiving services from the county child welfare agency. Age and gender of the focus children are balanced. Two-thirds of the children have been in out-of-home care during the previous six months, with the remaining one-third living with a parent and receiving in-home services. Up to twelve children are selected from each county, except in the largest counties, where twenty-four children may be reviewed.

During the course of the review, reviewers complete a trauma questionnaire for the focus child, the mother and father. Reviewers are given guidance on how to identify types of trauma by referencing the fourteen defined trauma-related events as identified by The National Child Traumatic Stress Network (NCTSN) (2003). The complete list of trauma types is included in Appendix 1.

Identification of trauma exposure comes from document review and interviews with the social worker and other collateral contacts. The quality of the information of these 349 focus children and their parents is most reliable in relation to the children themselves for whom available documentation is recent and comprehensive. Information on the focus children's mothers is often based on social histories taken by social workers, although the historical trauma exposure of mothers may not be complete. Trauma exposure of fathers is much less known, as many of the fathers of the focus children may be absent and have not had assessments. Absence of parents may be due to a variety of reasons, such as incarceration, location in another county or state, mental health issues and/or substance abuse.

A second source of information gathered during reviews is data collected relating to co-occurring conditions for the focus child and the parents. The data collection method does not delineate between the mother's and father's conditions, but documents whether the focus child or the parents were exhibiting any co-occurring conditions, such as mental illness or substance abuse. This lack of delineation does not allow an individual parent to be correlated to individual co-occurring conditions, but it gives an idea of the prevalence of these issues.

A third source is the focus groups that occur during the review week in each county. Each county has up to twenty focus groups comprised of key stakeholders in the community, child welfare agency staff, supervisors and managers, service providers, law enforcement, educators, judicial and legal partners. Focus groups provide an overview of how the county service delivery system meets the needs of children and families, as well as areas the stakeholders identify as service gaps.

Findings

The sample of families reviewed provides an insight into the prevalence and types of trauma families in Wisconsin experience. As the following charts will illustrate, the data shows there are a high number of families with exposure to trauma. Of the 349 focus children interviewed, a total of 302 or 87% of the focus children have been exposed to at least one traumatic event. Further, the data indicates the majority of focus children, their mothers and fathers, were exposed to multiple traumas. Wisconsin's data found a high incidence of problems with which those who have trauma exposure often contend. This is consistent with national research.

The data illustrated a high probability of co-occurring conditions for those exposed to trauma (see chart 6). The two most common co-occurring conditions found in the data include substance abuse and mental illness for parents and mental illness and behavior disorders for children. National research reports the causal relationship between adverse childhood experiences in a person's childhood and the use of alcohol and injected street drugs (Felitti, 2004). Van der Kolk stated it is clear that traumatized individuals develop a range of shifting maladaptive patterns, depending on their state of development, social support and relationship to the origin of trauma (n.d.).

As seen in chart 5, 191 children suffered from neglect, 144 children had an impaired caregiver and 119 children have domestic violence identified. The NCTSN supports these results by indicating ongoing substance abuse prevents parents from being consistently available and responsive to their children, thus leaving the child at risk for future victimization (2003).

The data shows only 9% of the children and 7% of mothers have received a trauma informed assessment. The NCTSN (2003) discusses the value of a comprehensive assessment for both complex trauma exposure and complex traumatic outcomes or adaptations. Although assessments are not standardized nationally, they have been proven effective (NCTSN, 2003).

Data

Chart 1 indicates the gender by age of the focus children reviewed. Fifty-two percent of the focus children are male and 48% are female.

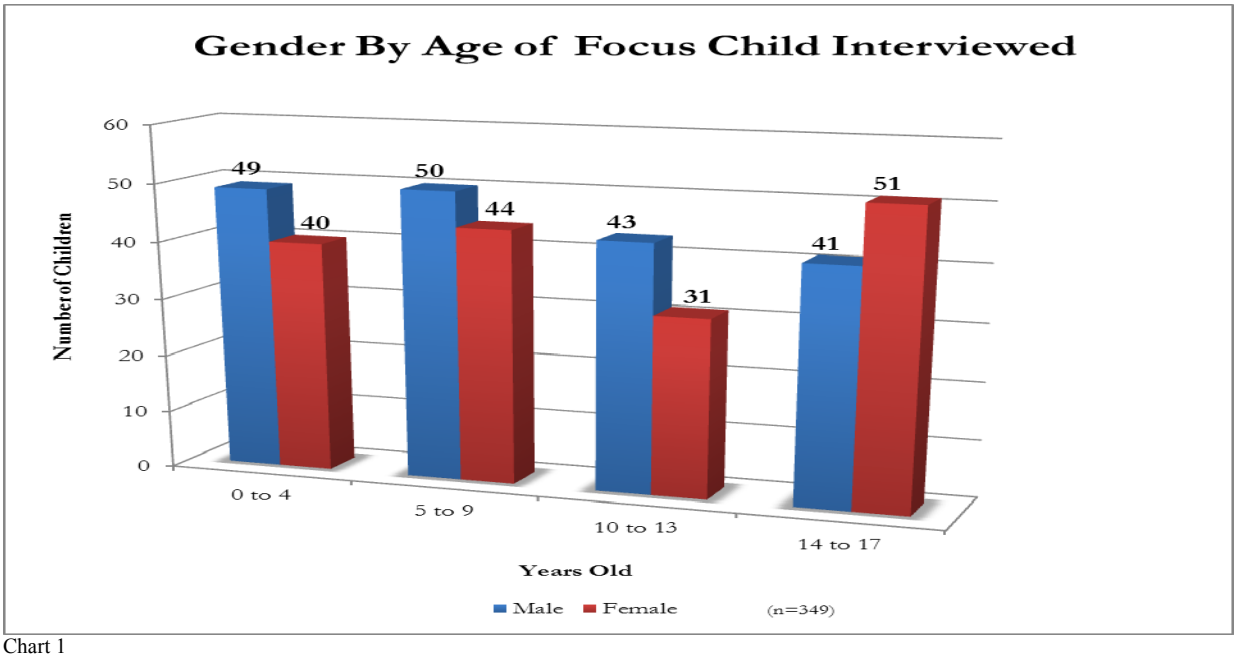

Chart 1

Chart 2 indicates the current placement of the focus children. The majority of the focus children, 204, were found to be living in out-of-home care. The category named "other," includes such placements as adoptive home, licensed relative foster home, independent living, detention/shelter, hospital/MHI, guardian, guardianship with stepfather and non-relative non-licensed court appointed placement.

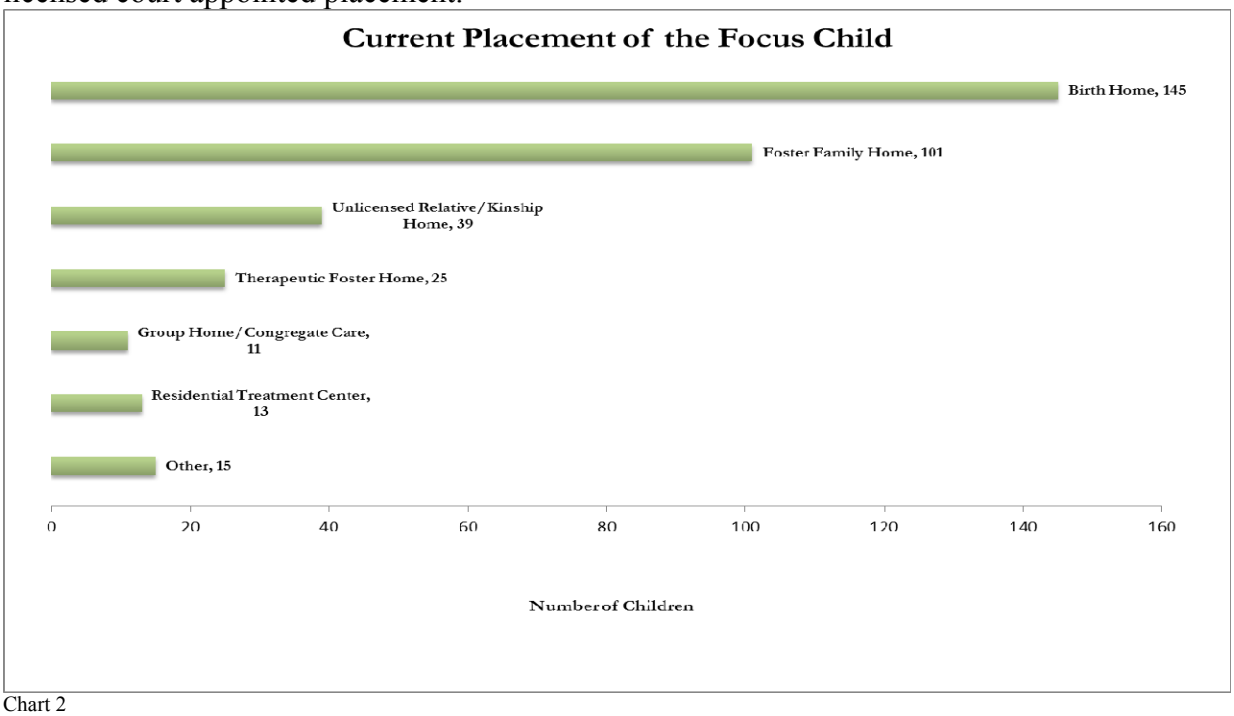

Chart 2

Chart 3 indicates the ethnicity of the 349 focus children reviewed, with 72% of the children identified as white.

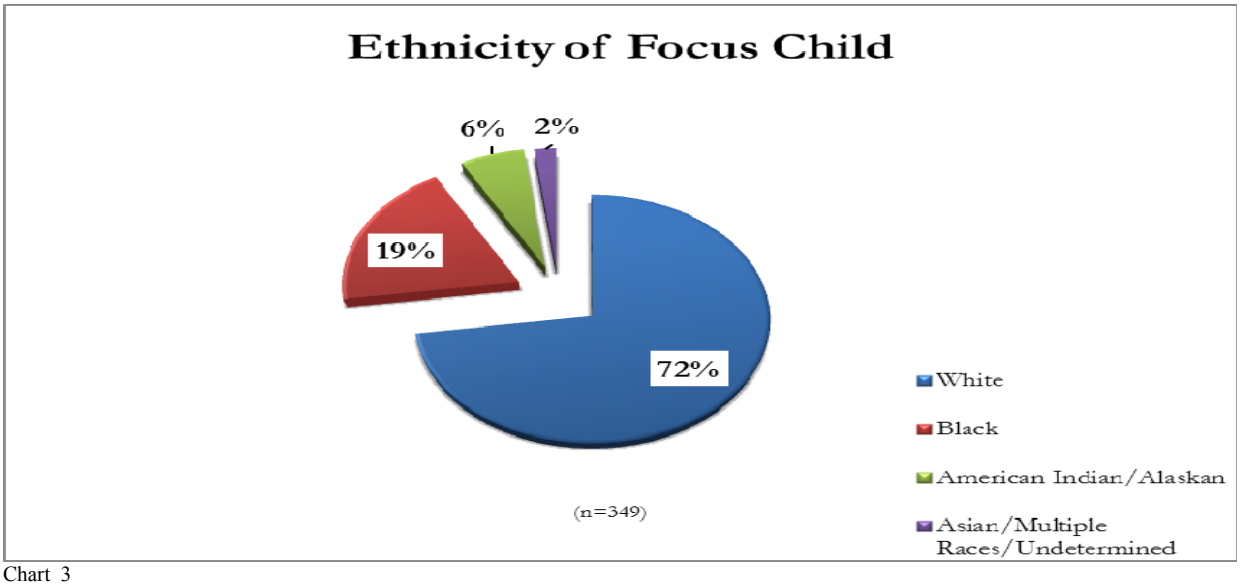

Chart 3

Chart 4 indicates that of the 349 cases reviewed, 302 focus children, 276 mothers and 90 fathers reported being trauma exposed. The unknown category includes persons who have not been interviewed or no information has been collected regarding trauma exposure.

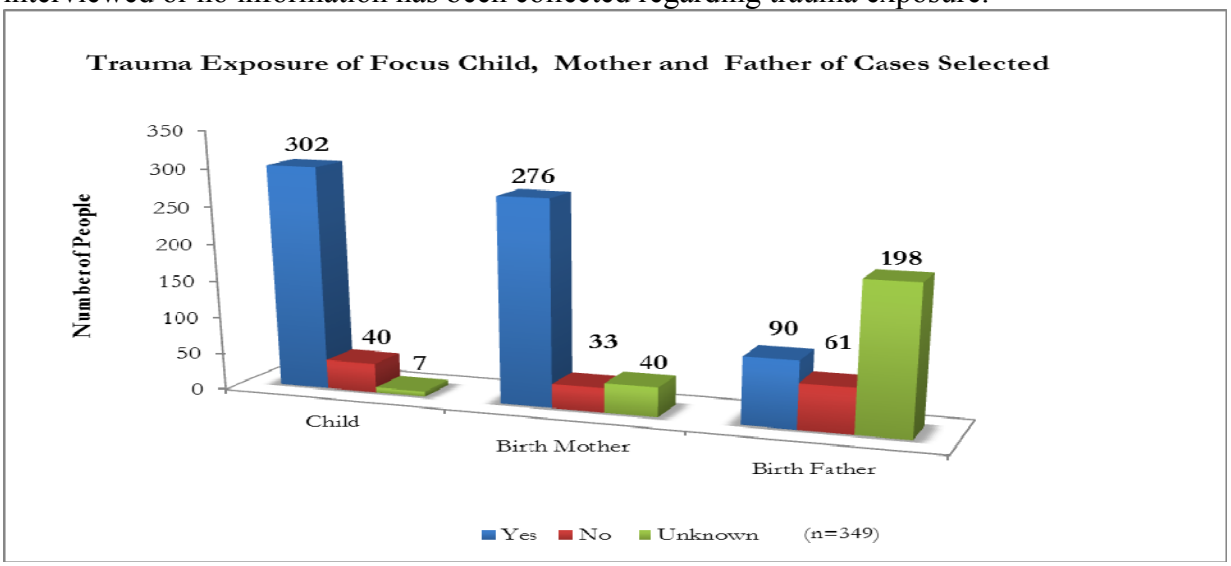

Chart 4

Chart 5 illustrates the types of traumatic events to which the focus child and respective mother were exposed. Of the focus children interviewed, the most prevalent trauma exposure was neglect, impaired caregiver, domestic violence and physical abuse. The mothers' most prevalent trauma exposures were sexual abuse/assault, interpersonal violence, traumatic grief, physical and emotional abuse. In comparing the data collected on the mothers to the data collected on the focus children, the data scored similarly in the traumatic grief, physical abuse and accident or illness categories.

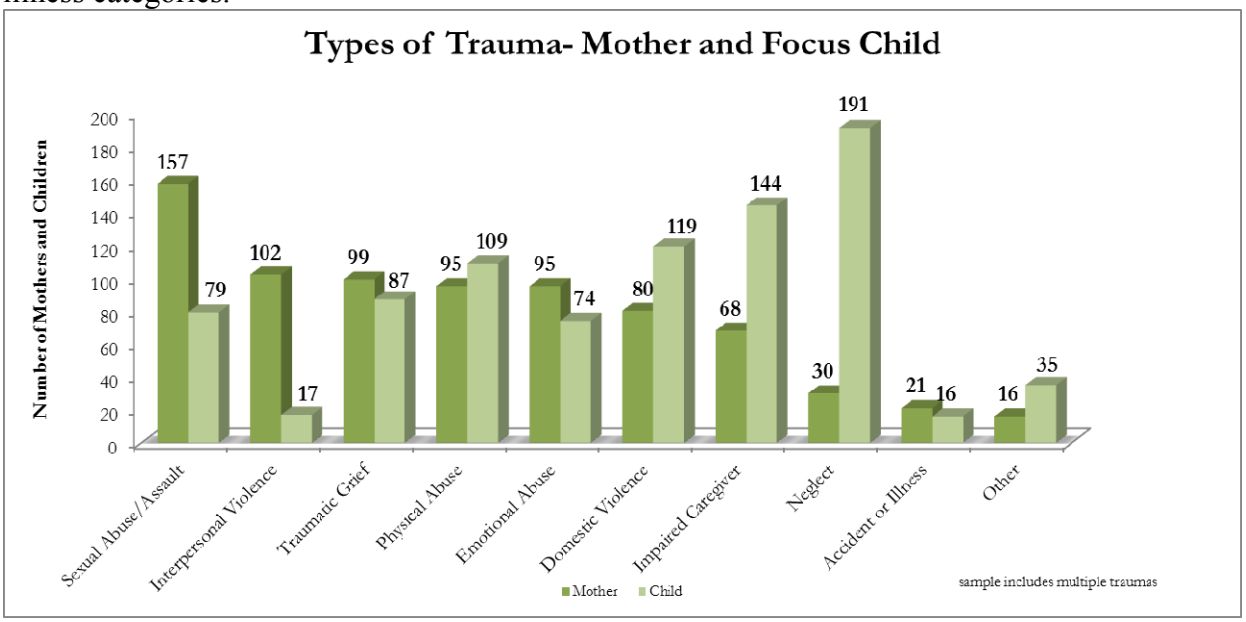

Chart 5

Ninety fathers were identified as being exposed to trauma. Of the fathers interviewed, the most prevalent trauma exposure was traumatic grief, impaired caregiver, physical and emotional abuse. Both mothers and fathers had higher levels of exposure to traumatic grief, physical and emotional abuse. Fathers and focus children reported higher incidents of having an impaired caregiver. Each individual reported may have experienced multiple types of traumas.

Chart 6 indicates mental illness and substance abuse were the most prevalent co-occurring conditions for mothers and fathers. Each individual represented may report multiple co-occurring conditions. Although reviewers are able to specify a child's co-occurring conditions, parents are not tracked individually.

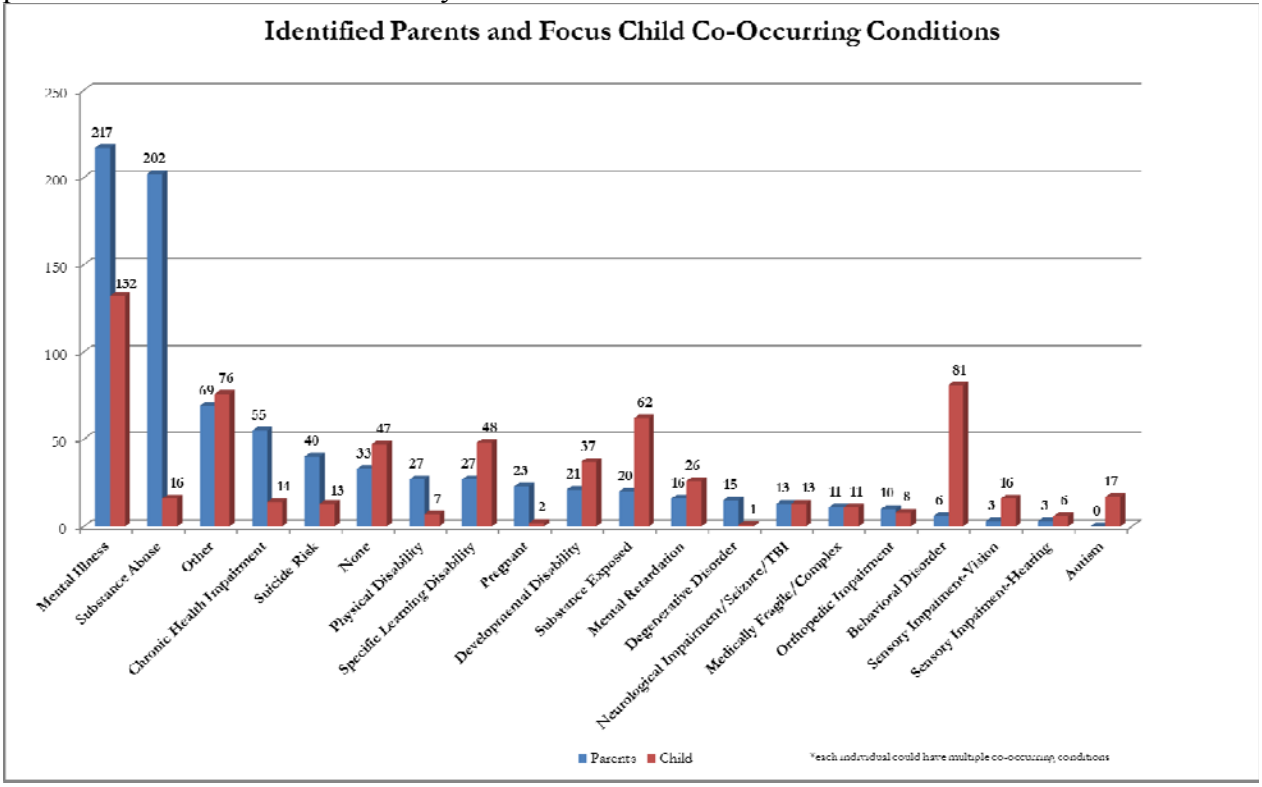

Chart 6

Observations

The combined data collection regarding trauma exposure in focus children, their mothers and fathers of those who are involved in CPS in Wisconsin suggests the following three concerns.

1. Of the 349 focus children reviewed, 87% had been exposed to trauma. According to the Wisconsin Child Abuse and Neglect Report for 2009, there were 4,289 child victims of substantiated maltreatment in Wisconsin. Given that focus children are selected for reviews through a random stratified process, it is reasonable to assume the group is representative of substantiated CPS cases statewide and would have a high percentage of exposure to trauma.

The sample showed 79% of the mothers reviewed had been exposed to trauma. Again, if the focus sample is representative of mothers involved in CPS cases statewide, it is reasonable to expect a majority had incidence of trauma in their lives.

2. As our data indicates, mental health is the most common of the co-occurring conditions; with substance abuse being the second most common. As research reports, children who are exposed to trauma, such as caregivers affected by substance abuse, tend to have mental health symptoms that are pervasive and multifaceted (van der Kolk, n.d.). These are likely to include Depression and impulsive, self-destructive behaviors (van der Kolk, n.d.). Felitti's research suggests a strong association between ACE's and later substance abuse. Research indicates compulsive use of alcohol and drugs increases in a manner that closely parallels intensity of adverse life experiences in children (Felitti, 2004).

3. According to the NCTSN (2003), regardless of the initial trauma event that prompts referral for treatment services, the accepted standard of care involves conducting a comprehensive or trauma-informed assessment. The review process collects information on whether a trauma assessment was completed for individuals identified as having trauma exposure. Data shows that less than 10% of the focus children and their parents had a trauma-informed assessment completed. Among the reasons identified for lack of assessments include lack of qualified providers and inability to pay for service.

The reviews provide insight into the number of families affected by trauma in Wisconsin and indicate that Wisconsin data mirrors national research in many areas. Persons in Wisconsin who have a history of trauma often experience substance abuse and mental health issues. Data suggests this can perpetuate the cycle of trauma in families and affect caregiver's parental capacities. Research suggests unmitigated trauma in parents can result in trauma for children, often in the forms of child abuse and neglect (NCTSN, 2003). A significant number of parents included in the review have been affected by trauma and without treatment; research indicates the cycle will continue (NCTSN, 2003).

Information collected from focus groups and case interviews indicate trauma-informed practice, including assessments and delivery of trauma-informed care, is not readily available across Wisconsin. National data suggests the impact on society of unmitigated trauma is profound in terms of costs and the increase of complex family needs, which suggests it is reasonable to assume the impact on Wisconsin's families is also profound (NCTSN, 2003). Communities need to build their capacity to deliver trauma-informed care services to achieve safety, permanency and well being for their children and families and develop community building activities to reduce ACES over the long term.

National data reports the total annual costs of child abuse and neglect has been estimated to be 94 billion dollars nationally, 258 million dollars daily (NCTSN, 2003). The estimates include both direct costs such as mental health and law enforcement; and indirect costs such as lost productivity and criminality (NCTSN, 2003). As research suggests, the prevalence of unresolved trauma is a determinant of the health and social wellbeing of our nation from the

perspectives of social costs, health care, effects of public policy and the quality of human and social existence (Felitti, 2004). Engaging in efforts aimed at closing the gap between the needs of children and families impacted by trauma and the resources available to them is crucial.

The Department of Children and Families Secretary Eloise Anderson is committed to incorporating trauma informed care into Wisconsin's child welfare system to break the cycle of neglect, child abuse, mental health and substance abuse issues. The data collected from the reviews indicates a high incidence of trauma and verifies Wisconsin indeed must place much more emphasis in trauma informed care.

Appendix 1. Child Welfare Trauma Training Toolkit: Trauma Types

Source: The National Child Traumatic Stress Network, March 2008

1. **Sexual Abuse or Assault**

*NOTE: If perpetrator is in a caretaking role for youth, event is classified as **sexual abuse**. Sexual contact/exposure by others (i.e., non-caretakers) is classified as **sexual assault/rape**.*

■ Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child.
■ Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children).
■ Unwanted or coercive sexual contact or exposure between two or more minors.

2. **Physical Abuse or Assault**

*NOTE: If perpetrator is in a caretaking role for youth, event is classified as **physical abuse**. If event afflicted by others (i.e., non-caretakers) is classified as **physical assault**.*

■ Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation) by an adult, another child, or group of children to a minor child with or without use of an object or weapon and including use of severe corporeal punishment.
■ Does not include rough and tumble play or developmentally normative fighting between siblings or peers of similar age and physical capacity (e.g., assault of a physically disabled child by a non-disabled same-aged peer would be included in this category of trauma exposure).

3. **Emotional Abuse/Psychological Maltreatment**

■ Acts of commission against a minor child, other than physical or sexual abuse, that caused or could have caused conduct, cognitive, affective or other mental disturbance. These acts include:
a. Verbal abuse (e.g., insults; debasement; threats of violence)
b. Emotional abuse (e.g., bullying; terrorizing; coercive control)
c. Excessive demands on a child's performance (e.g., scholastic; athletic; musical; pageantry) that may lead to negative self-image and disturbed behavior
■ Acts of omission against a minor child that caused or could have caused conduct, cognitive, affective or other mental disturbance. These include:
a. Emotional neglect (e.g., shunning; withdrawal of love)
b. Intentional social deprivation (e.g., isolation; enforced separation from a parent, caregiver or other close family member)

4**. Neglect**

■ Failure by the child victim's caretaker(s) to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. Includes:
a. Physical neglect (e.g., deprivation of food, clothing, shelter)
b. Medical neglect (e.g., failure to provide child victim with access to needed medical or mental health treatments and services; failure to consistently disperse or administer prescribed medications or treatments (e.g., insulin shots)
c. Educational neglect (e.g., withholding child victim from school; failure to attend to special educational needs; truancy)

5. **Serious Accident or Illness/Medical Procedure**

■ UNINTENTIONAL injury or accident such as car accident, house fire, serious playground injury, or accidental fall down stairs (accident caused intentionally by another would be classified as Physical Abuse or Assault).
■ Having a physical illness or experiencing medical procedures that are extremely painful and/or life threatening. Examples of illnesses include AIDS or cancer. Medical procedures include changing burn dressings or undergoing chemotherapy, etc.

6. **Witness to Domestic Violence**
■ Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a parent/caretaker and another adult in the child victim's home environment.
■ Exposure to any of the above acts perpetrated by an adolescent against one or more adults (e.g., parents, grandparent) in the child victim's home environment.

7. **Victim/Witness to Community Violence**
■ Extreme violence in the community (i.e., neighborhood violence). Includes exposure to gang-related violence (e.g., drive-by shootings).

8. **School Violence**
NOTE: School Violence may be scored under Victim/Witness to Community Violence
■ Violence that occurs in a school setting. It includes, but is not limited to, school shootings, bullying, interpersonal violence among classmates, classmate suicide.

9. **Natural or Manmade Disasters**
■ Major accident or disaster that is an unintentional result of a manmade or natural event (e.g., tornado, nuclear reactor explosion).
■ Does NOT include disasters that are intentionally caused (e.g., Oklahoma City Bombing, bridge collapsing due to intentional damage), which would be classified as acts of terrorism/political violence.

10. **Forced Displacement**
NOTE: Kidnapping would be scored under Forced Displacement
■ Forced relocation to a new home due to political reasons. Generally includes political asylees or immigrants fleeing political persecution. Refugees or political asylees who were forced to move and were exposed to war may be classified here and also under war/terrorism/political violence.

11. **War/Terrorism/Political Violence**
■ Exposure to acts of war/terrorism/political violence. Includes U.S. incidents such as the Oklahoma City bombing, the 9/11 attacks, or anthrax deaths. Includes incidents outside of the U.S. such as bombing, shooting, looting, or accidents that are a result of terrorist activity (e.g., bridge collapsing due to intentional damage, hostages who are injured during captivity). Includes actions of individuals acting in isolation (i.e., sniper attacks, school shootings) if they are considered political in nature.

12. **Victim/Witness to Extreme Personal/Interpersonal Violence**
■ Includes extreme violence by or between individuals that has not been reported elsewhere (hence, if the child witnessed domestic violence, this should be recorded as Witness to Domestic Violence and NOT repeated here).
■ Intended to include exposure to homicide, suicide and other similar extreme events.

13. **Traumatic Grief/Separation**
■ Death of a parent, primary caretaker or sibling.
■ Abrupt, unexpected, accidental or premature death or homicide of a close friend, family member, or other close relative.
■ Abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling due to circumstances beyond the child victim's control (e.g., contentious divorce, parental incarceration, or parental hospitalization). Does not include placement in foster care.

14. **Impaired Caregiver**
■ Exposure to a caregiver who suffers from alcohol or other drug addiction, severe Depression or other mental health condition, or a physical condition in which the caregiver is unable to function i.e. get up out of bed, maintain employment or basic home management responsibilities.

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